

AUSCR DATA ENTRY CHECKLIST

LOGIN

- Each user should have, and use, their own user ID & password.

DATA ENTRY— Creating a New Patient

Click on **patient**, then click on **new patient**.

- ⇒ A new patient screen will appear. Complete all the required boxes and the Medicare number.
- ⇒ Check the spelling of the name and date of birth carefully, then click **save**.
- The four data items to create a patient record – first name, last name, date of birth and Medicare number – **cannot be changed by Hospital Users** and must be amended by AuSCR office.
If you find a mistake after you have saved an entry in the Create New Patient screen:
 - ⇒ Delete the record.
 - ⇒ Then create another new patient record.
The AuSCR web tool administrator will automatically get the list of deleted records and will remove it permanently on a regular basis.
If you have continued with the data entry and have entered episode data as well:
 - ⇒ Email the AuSCR Office which can change any of the four core data items via the backend of the database.

DATA ENTRY— Creating a New Episode

- ⇒ New episodes can only be created after a Patient Record has been created and saved.
- ⇒ First search for the patient using the **search** button, then click on the correct patient to whom the new episode is to be linked.
- ⇒ Click on the **New Episode** button at the bottom of the Patient Record.
- ⇒ You will need the information from the patient's hospital medical records, or a completed AuSCR Data Collection Form, to provide sufficient information to create a new episode .
- ⇒ The information includes: admission information, clinical information, discharge information, and if relevant, death information.

DATA ENTRY— Creating a New Episode (cont.)

- ⇒ All information boxes marked with an (*) in the episode screens are mandatory. The episode cannot be saved if any of these boxes is incomplete.
 - ⇒ In the Admission Information section, the date and time of admission must be entered. Please review the rules on the date and time estimates outlined in the AuSCR Hospital User Manual or Data Dictionary.
 - ⇒ Note that if the patient did not arrive in Emergency prior to admission to the hospital, e.g. if the patient was admitted for elective surgery, the rule of Not Applicable will apply. In these cases, enter 01/01/1900 and 99:99 for the date and time of arrival respectively.
 - ⇒ ICD-10 codes can be completed at a later date when the information is available from Medical Records.
 - ⇒ Complete the Discharge Information when the patient is discharged from acute care
 - ⇒ For the Discharge Destination question, select Not Applicable for the care plan question if the Discharge Destination is Rehabilitation (Inpatient) or another hospital or SNAP.
 - ⇒ After you have completed all boxes and saved the episode, the Activity Status should be ACTIVE and the Completion Status should be INCOMPLETE, which will allow you to return and edit the information.
- If you are using earlier versions of IE (version 6 or 7) or Firefox/Chrome, it is possible that there could be instances in which the data entered might not be saved properly into the database. Some sites have experienced this issue when saving discharge information such as date of discharge.

It is always advisable to separate data entry for the episode data:

- ⇒ First, enter admission and clinical information and save this part of the episode data.
- ⇒ Then, click Edit and enter the discharge information and save.

EDITING OR DELETING DATA

- Data can be added or changed later if unknown at the time. For example, type of stroke can be recorded as 'Undetermined' initially but this response should be edited once the stroke type has been confirmed
- Patients entered into AuSCR whose final diagnosis is not stroke or TIA should be removed.
 - ⇒ The removal of non-stroke patients can be undertaken by the Hospital Administrator at each site or by the Data Manager at AuSCR office.
 - ⇒ If you require a non-stroke patient to be removed from the registry, please contact the AuSCR office: admin@auscr.com.au.